Maryland CANCER FUND

Cancer Treatment Plan and Budget

Name of Organization/Entity applying for Grant: _____

Patient Name: _____ Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Comments: _____

_____

Treatment Plan from _____ to _____ Primary Treating Physician's Name: ___ _____
(date) (date)

Procedure and Frequency of Treatment	**Date Anticipated**	**Estimated Costs**	**Basis for costs (Medicaid rate, HSCRC-regulated rate, or MHIP rate)**
Sub Total for Treatment			
Indirect costs (Maximum of 7%)			
Total Requested (Treatment + Indirect)			